DEPARTMENT:	Utilization Management (UM)	**ORIGINAL APPROVAL:**	07/13/2000
POLICY #:	UM.203	**LAST APPROVAL:**	10/14/2009
TITLE:	Prior Authorization (PA) and Precertification		
APPROVED BY:	Medical Management Leadership Team		
DEPENDENCIES:	Utilization Management Policy UM.204: Denial Process Utilization Management Policy UM.205: Timeliness of UM Decision Making Utilization Management Policy UM.215: External Peer Review Process		

PURPOSE

The purpose of this policy is to demonstrate the commitment of Community Health Plan (CHP) to conduct prior authorization and precertification for routine and urgent services in compliance with relevant contracts and Federal and State regulations.

POLICY

Prior authorization and precertification are required from Community Health Plan (CHP) for certain services, items or supplies through the Utilization Management (UM) department. Since the goal of prior authorization/precertification is to make a proactive impact on quality and value, authorization for routine and urgent services must take place before the service is provided. For emergency services, no prior authorization is necessary.

CASE REVIEW

The UM Coordinators and Case Managers shall use the following in decision making:

- Information requested from providers
- Departmental policies and procedures
- Consideration of the needs of the individual member
- Characteristics of the local delivery system, including the availability of the proposed services within the network service area.

Approval Authority

The UM Coordinators and Case Managers shall have the authority to approve services based on medical necessity. If the decision is outside the bounds of the staff member's authority, the case is referred to the Medical Directors for review and determination.

The Medical Directors, Pharmacists and Associate Clinical Director, who are under the supervision of the Chief Medical Officer, are the only Plan representatives with the authority to deny payment for services based on medical necessity and appropriateness. Prior authorization and precertification decisions are made according to criteria endorsed by the CHP Board of Directors. The Medical Director, Pharmacist or Associate Clinical Director responsible for the

decision may override the established criteria if the service, item, or supply is deemed to be in the Plan's best interest.

Alternatives for denied care/services are given to the requesting provider and member and are based on the criteria set used or individual case circumstances. In making determinations based on contract benefit exclusions/limitations, the Member Handbook and posted benefit grids are used as references. The Member Handbook and benefit grids are also posted on the CHP website as a resource for members (www.chpw.org).

No Reward or Penalty for Utilization Management Decisions

CHP staff and contractors are not rewarded or penalized for authorizations or denials. Each certification decision is made on its own merit, according to a review of the submitted information and in accordance with established guidelines. Utilization Management decision making is based only on appropriateness of care and service and existence of coverage. CHP does not use incentives to encourage barriers to care and/or service.

Accepted Communication Formats

Providers shall notify CHP of a service request by fax. Amendments or other changes may be made telephonically. A provider may submit either a CHP *Prior Authorization Request* form or a *Washington Healthcare Forum Prospective Medical-Clinical Review* form.

Medical Necessity

Information is used in the determination of medical necessity, and may include:

- Patient name*, ID#*, age, gender
- Clinical documentation received
- Medical history
- Diagnosis*, co-morbidities, complications
- Signs and symptoms
- Progress of current treatment, including results of pertinent testing*
- Providers involved with care
- Proposed services*
- Referring physician's plan of care
- Psychosocial factors, home environment

* = required

Additional information from the patient's medical records may be requested if it is reasonably necessary to accurately apply the relevant medical necessity criteria.

Enrollee Right to Privacy

CHP Medical Management staff assures that enrollee's right to privacy and confidentiality are protected. Only information applicable to the condition being treated/service being requested is sought and retained. Corporate and departmental policies established for HIPAA compliance are followed.

Criteria & Guidelines

CHP uses a combination of Plan-developed criteria and Milliman Care Guidelines® to form its decisions.

CHP-Developed Criteria

- Plan-developed criteria are based on contract requirements, review of best clinical practices, review of the medical literature, and review of industry and community-practice standards.
- External sources such as Qualis, Hayes Plus, and Hayes, Inc. are also used for clinical decision-making; the physician reviewer will also consult with appropriate Board Certified specialists, including specialists in mental health, for medical appropriateness decisions as necessary. (UM Policy 215)
- A copy of CHP guidelines may be obtained from CHP's website (chpw.org); a copy of individual criteria set may be obtained from the website or by calling CHP customer service (800-440-1561).

Milliman Care Guidelines®.

- Member clinics are licensed for direct access to Milliman Care Guidelines®.
- Milliman Guidelines may be obtained by Affiliate clinics on a case-by-case basis.
- A copy of a specific Milliman guideline may be requested by calling CHP Customer Service (800-440-1561) or by email (guidelinerequests@chpw.org).

PRIOR AUTHORIZATION DECISIONS

PA medical appropriateness decisions are made by Medical Management staff. The UM Manager (or designee) monitors the consistency and timeliness of the UM/CM staff in handling approval and denial decisions, including notification of the decision to providers and members.

Enrollee, provider, clinic/vendor staff have access to PA decision-makers via telephone, fax or e-mail.

Approvals

Approvals shall be made by Utilization Management (UM) Coordinators, UM Nurse Coordinators, UM Manager, Care Coordinators, Case Managers, MSW Care Coordinators, CM Manager, Manager of Care Coordination and Behavioral Health, CHP Medical Director, Chief

Medical Officer, Clinical Pharmacist (for pharmacy decisions) and Associate Clinical Director (contracted).

Denials

Denials shall only be made by the CHP Medical Director, Chief Medical Officer, Pharmacist or Associate Clinical Director.

Documentation of Medical Appropriateness

PA medical appropriateness decisions shall be consistently documented. Documentation includes:

- Accurate entry into the medical management system (JIVA)
- Documentation of clinical criteria used to make the decision
- Clinical documentation provided to make decision attached to the episode in JIVA
- Documentation of sending the request to Second Level Review
- Documentation of correct rationale for any denial in letters to members and providers

Monitoring

UM activity shall be monitored throughout the year for timeliness and accuracy.

Analysis

Decisions for inclusion of items/services on the PA list are determined, in part, by annual analysis of PA tracking information and encounter data.

LIST OF APPENDICES

None.

CITATIONS & REFERENCES

CFR		
WAC		
RCW		
CONTRACT CITATION	☒ BH (BHS, BH-SUB, BH-HCTC)	
	☒ HO/SCHIP (HO, SCHIP, S-MED, BH+)	
	☒ GA-U	
	☒ WHP	
	☒ MA	
OTHER REQUIREMENTS	–	
NCQA ELEMENTS	2010 NCQA UM 4, UM5, UM 6, UM 7	

REVISION HISTORY

REVISION DATE	REVISION DESCRIPTION	REVISION MADE BY
07/13/2000	Original	UM/CM Manager
09/28/2005		UM Manager
10/25/2006		Georgette Cortel
11/13/2007	Formatting, add reference to Care Coordinators	Georgette Cortel
4/3/09	Added additional language regarding non-physician reviewers	Tracey Gunderson
4/14/09	Added language regarding appropriate UM professionals per NCQA	Sandra Hewett
8/14/09	Revised for NCQA Compliance	Marcia Bush Mike Hays Christa Lilienthal
10/14/09	No changes	Verni Jogaratnam
11/09/2009	Moved to new template; edited for style and clarity; requested form appendices;	Jennifer Carlisle